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Mercy Health System
1000 MINERAL POINT AVE.
JANESVILLE, WI 53545
608-756-6800

August 14, 1997

Department of Veteran Affairs
Regional Office and Insurance Center
Bishop Henry Whipple Federal Building
One Federal Drive
St. Paul, MN 55111-4050

To Whom It May Concern:

I am writing you in regards to Wilson Krueger, who had several questions regarding his service connection after a rating decision dated June 24, 1974, awarded service connection for cardiovascular disease including hypertension with an evaluation of 60% effective August 6, 1996. Mr. Krueger had several questions regarding this rating and it was his opinion that his service connection should be 100% effective June 2, 1974, to the present date.

I have thoroughly reviewed records from his October 1973 hospitalizations, reports of stress tests, which are all include in the medical record, as well as his most recent cardiovascular course beginning in September 1993 when he suffered an acute inferolateral myocardial infarction. He received thrombolytic therapy, cardiac catheterization, and emergency angioplasty of 90% left circumflex lesion. More recently, he has been under my care since September 23, 1996, after he began developing recurrent symptoms of angina in August 1996. His electrocardiogram in the office at that time was unremarkable and he underwent a Cardiac catheterization on September 27, 1996. This revealed a disease dilated right coronary artery with 35% stenosis in its proximal portion, a 30% stenosis in its midportion, a 30% stenosis at the crux, and a 20% stenosis at the origin of the first posterior descending artery. There was a 70% stenosis in the distal third of the posterior lateral division. His left main coronary artery was

normal. His left anterior descending artery contained a 50% stenosis in its proximal portio and a 35% stenosis between the first and the second anterior diagonal. There was 30% stenosis in the proximal portion of the circumflex artery. There was a 60% stenosis beyond the origin of the first obtuse marginal circumflex, and a 50% stenosis at the origin of the obtuse marginal circumflex. Ventriculography at that time revealed an ejection fraction of 70%. He was deemed to have a mild to moderate degree of three-vessel coronary artery disease and subsequently underwent a dobutamine stress echo on October 16, 1996, to evaluate the functional significance of his coronary artery disease. He obtained a peak heart rate of 122 on 20 mcg/kg per minute of dobutamine. He had frequent premature ventricular contractions, bigeminy, and a five-beat of ventricular tachycardia. There was inducible hypokinesis of the midposterior wall corresponding to his circumflex disease. The remaining segments appeared to be normal. Because of the complexities of the lesion in his left circumflex and the finding that only his posterior wall was ischemic, maximization of medical therapy was first attempted in the management of Mr. Krueger. He did reasonably well until he was rehospitalized on February 9, 1997, at the University of Wisconsin Hospital with unstable angina. He underwent an angioplasty involving the origins of his first obtuse marginal and second obtuse marginal vessels on February 11 and this angioplasty was successful. He was subsequently discharged. He participated in cardiac rehabilitation prior to his angioplasty and after this as well. He subsequently developed recurrent angina and was admitted to the hospital for a cardiac catheterization on March 10, 1997. This revealed progression of coronary disease in all vessels with the greatest stenosis in his right system being 65% at the origin of the posterior lateral division as well as multiple 35-5O% lesions in that vessel. The proximal anterior descending artery contained a 50%. There was a 40% stenosis after the first anterior diagonal artery and a 30% stenosis prior to the second anterior diagonal artery. The first anterior diagonal artery contained a 40% stenosis. There was a 30% stenosis in the proximal circumflex artery and a 60% stenosis proximal to the origin of the obtuse marginal circumflex, increasing to 75% immediately beyond the origin of the obtuse marginal circumflex. There was a 50% stenosis at the origin of the obtuse marginal circumflex. Because of his accelerated angina, he

was then taken for coronary artery bypass surgery March 13, 1997, receiving left internal mammary artery graft to his left anterior descending artery, a saphenous vein graft to the anterior diagonal artery, a saphenous vein graft to his obtuse marginal circumflex, a saphenous vein graft to his right coronary artery and to the junction of his distal right coronary artery and posterior descending artery. Although his postoperative course was complicated by metabolic acidosis, he eventually did well and was discharged on March 21, 1997. He has had a steadily improving course and we are very happy with his outcome, although he did have problems with disunion of his sternum, which is being followed by Dr. Gordon. He has had no recurrent episodes of angina pectoris.

In review of the rating decision mentioned above, there does seem to be a contradiction in the reasons and basis section, paragraph #2, explaining the reason for denial in my review of the medical record. Specifically, it states in that second paragraph that the record contains no competent medical opinion or authority that links or relates the veteran's current cardiovascular disease to any clinical finding during the period of his active service. However, in my review, it is clear that Mr. Krueger had essential hypertension as defined a systolic blood pressure greater than 140 and a diastolic blood pressure greater than 90. This began back on December 12, 1969, when his blood pressure was 154/100. At the time of his admission on October 8, 1973, his blood pressure wall 190/130. This is documented on a clinical record dated October 8, 1973, when he was admitted with cheat pain. He was ruled out for myocardial infarction. He had normal cardiac enzymes. He was hospitalized between October 8 and October 11.He apparent underwent both a single and a Double Master test. The single Master test being in January 1974 and the Double Master test, however, revealed 2 mm of ST segment depression in leads II, aVF, and 3 mm in V5. This would consistent with objective evidence for coronary ischemia, although I do not have the actual tracings for my review. He underwent a cardiac consultation and was given a provisional diagnosis on the base of his Double Master test of coronary artery disease. During that cardiology visit on January 24, 1974, his blood pressure was 155/95. Although no formal diagnosis of hypertension was made at that time, this was

error, and the evidence of elevated blood pressure above 140/90 on several occasions, in my opinion, establishes a diagnosis of hypertension. The patient underwent a third exercise treadmill study, which reportedly was normal, though again I do not have the actual tracings for my review. On that exercise treadmill study, his blood pressure was elevated throughout the study, although it was not inappropriate for exercise.

In my opinion, Mr. Wilson Krueger should have had the diagnosis of hypertension made in December 1969 and it certainly should have been made when he was admitted on October 8, 1973. Since he has been following with me, he has always been treated for hypertension. In my opinion, this began back in 1969. Given these findings, it is my opinion that hypertension did contribute to Mr. Krueger's coronary disease. As you know, it is a significant risk factor for the development of coronary atherosclerosis and myocardial infarct as well as kidney disease, peripheral vascular disease, and stroke. Since there is evidence that Mr. Krueger had essential hypertension while he was in active service and this hypertension was not formally diagnosis and its undiagnosis likely led to acceleration in development in atherosclerosis, I would have to agree with Mr. Krueger's opinion that his 100% service connection should be awarded back to his date of separation, June 2, 1974. Once again, Mr. Krueger's hypertension should have been formally diagnosed and treated if not in 1969, certainly in October, 1973. Finally, Mr. Krueger asked me to comment whether his chest pain that he had on the admission of October 8, 1973, represented coronary artery disease. Certainly not having formally examined him at that time, this would be a difficult determination. However, I do find it curious that one Double Master test had objective evidence of coronary ischemia on that study. The mere absence on a subsequent study simply reflects the dynamic nature of coronary artery disease. Given his symptoms of angina an one abnormal exercise treadmill study, I think it would have been reasonable to perform a cardiac catheterization at that time to exclude and evaluate his cheat pain formally. He did wonder why he was hypertensive on his Master two test; however, in my opinion, the blood pressure elevation during his exercise treadmill study is normal for that level of exercise and as you know blood pressure elevation during exercise is a normal finding as long as it

is not extensive. Finally, in May 1993 he was told he had 40% damage to his heart; however, in my opinion, on review of those records the damage due his myocardial infarction was limited to a very small area of the inferior lateral wall and probably represents only 5-10% of his myocardium and on subsequent echocardiograms in 1996 and 1997 this has subsequently completely resolved.

Thank you very much for your consideration. Please call my office if you have any questions.

Sincerely,

Signed
Ivan J. Chavez, MD
Department of Cardiology

IJC/km

Riverview Clinic
580 N. Washington Street
P.O. Box 551
Janesville, WI 53547-0551
(608) 755-3500 - (800) 779-2885

Mr. Wilson Krueger, Jr.
W1343 Brooklyn-Albany Road
Albany, WI 53502

Dear Mr. Krueger:

I reviewed the VA records that you brought with your appointment at your request. As you know, our concern is to determine weather the blood pressure that you have suffered was a Service-connected or a service-related illness.

The blood pressure measurements recorded between December 1969 and June 1974 (your DOS) indicate that during the time of your Military Service, Specifically between 1969 and 1974,that elevated blood pressure was present. Theoretically, one could claim that your blood pressure was elevated before Military Service, but I presume that would have been detected in your Military examination at the time of Military Enrollment.

To summarize, my review of the extensive records that you brought here reveal that your blood pressure was, as far as we can tell, normal at the time you enrolled in the Military Service and therefore, was a medical condition that was present at the time of discharge from Military Service. Therefore, in my opinion, it is more likely than not that the onset of high blood pressure took place in Military Service.

If there is any further question about this issue, please give me a call.

Sincerely,

Signed
Daniel T. Peterson, M.D.
Department of Internal Medicine

DTP:rw

Aberdeen-Monroe County Hospital
400 South Chestnut Street
P.O. Box 747
Aberdeen, Mississippi 39703

October 15, 1997

Mr. Wilson Krueger:
We are a small hospital and do not have reproductive equipment for microfilm. I have transcribed this from the microfilm for you.

Admitted January 31, 1966. Discharged February 1, 1966.

Diagnosis: Coronary Insufficiency

PRESENT ILLNESS: This patient was outside with a torch thawing his water pipes when all of a sudden an acute pain struck him in the chest radiating into his left arm. The pain was severe enough that he doubled up. This pain radiated into the neck and pain on expiration and inspiration was excruciating. The heart had an irregular rhythm. Tones were distant. PMI's were well within the mid clavicular line. There was an occasional extra systole present.
IMPRESSION: Acute Allergic Bronchitis with coronary insufficiency on the basis of toxic fumes.
EKG: 2-1-1966 Remarks: Coronary insufficiency due to toxic. Pulmonary obstruction. Allergic Chemical Reaction.
EKG: 1-31-1966 Remarks: Coronary insufficiency due to toxic. Normal EKG Pulmonary obstruction.

Sincerely, 10/15/97

Signed
Margaret Hearis-Alexander

Signed
Celeste Cockerham

My commission Expires September 18, 2000
Medical Record Department
August 25, 1998
In Reply Refer to: 027E

Standard Form 502
CLINICAL RECORD
Date Admission 8 Oct 73 DATE Of Discharge 21 Oct 73
NUMBER OF DAYS HOSPITALIZED 003

HISTORY OF PRESENT ILLNESS: The patient is a 39-year-old Caucasian male who one hour prior to admission developed right parasternal chest pain which was cramping in nature and associated with shortness of breath and diaphoresis. There were no other associated symptoms, and the patient had no previous history of hypertension, diabetes, cardiac or pulmonary disease. The patient takes no medication except Valium for back pain. The rest of history is relatively unremarkable except for a possible peptic ulcer diagnosis in 1967, and a laminectomy done for HNP in 1969. The patient is a non-smoker and takes only occasional alcohol.

REVIEW OF Systems: Unremarkable. Initially was 190/130. Pulse was 90 and regular. Temperature was 97.7. Height 6 feet. Weight 215. The patient was alert cooperative Caucasian male in no distress. Skin, HEENT, lymphatics were all within normal limits. The neck showed no thyromegaly. The chest was clear top A&P, and there was no chest wall tenderness. Cardiac apex was not palpable. The left lateral border was at the fifth intercostal space 2 cm. Medial to the mid- clavivular line. S-1 and S-2 were with in normal limits. There were no S-4's or murmurs, and there was an intermittent S-3 at the apex in the left lateral decubitus position. All peripheral pulses were within normal limits. No bruits were noted. The abdomen and the rest of the physical exam were within normal limits.

Initial impression was chest pain, to rule out acute myocardial infarction, and the patient was hospitalized.

LAB DATA: Hemoglobin 15.3, white count 3800 with 51 neutrophils, 44 lymphocytes,
2 eosinophiles, 3 monocytes. Sed Rate was 9 mm. Per hour. UA was within normal limits. Glucose was 95. Urea, BUN was 13.3 sodium 141, potassium 4.9, chloride 101.4 and C02 combining power was 28. A cardiac enzyme showed SGOT of 16, 22, and 16 unites on three consecutive days. LDH was 363, 360 and 360 on three consecutive days. Calcium was 5.1, and an alkaline phosphate was 2.0. Phosphate was 4.1. Chest x-ray was within normal limits. EKG's done on four consecutive days showed no

significant change, and were all within normal limits. An oral cholecystopgram was performed and was within normal limits.

HOSPITAL COURSE: The patient was initially placed on bed rest with an IV and placed on the cardiac monitor. He was given 100mg Demerol Initially With relief Of pain, and he had no subsequent pain throughout his hospital course. The patient was felt by the third hospital day to have not suffered a myocardial infarction or significant pulmonary disease, and was discharged to be followed as an out-patient.
DISCHARGE MEDICATIONS: Valium, 5mg. Four times a day prn.
FINAL DIAGNOSIS: 7837 - Chest pain (musculoskeletal)

Signed
R.H.Choplin, Capt. USAF, MC
DATE 19 OCT 1973

KRUEGER, WILSON, M., JR.
Register No. 21520
AD AP TSGT
558-44-6389
USAF HOSPITAL, BLYTHEVILLE AFB AR ($AC)
RHC/fkp

X

Wilson M. Krueger, Jr.
W1343 Brooklyn-Albany Road
Albany, Wisconsin 53502

August 25, 1998

Re: Wilson M. Krueger, Jr. v. Togo D. West, Jr., Vet. App. No. 96-212

Dear Mr. Krueger,

In your August 10, 1998, letter to the Office of the General Counsel, you said that you were in the process of requesting further review of your VA disability claim by the Supreme Court of the United States. You requested that this office provide you with two copies - one copy for yourself and one copy for the Supreme Court - of all documents sent to or from the Board of Veterans' Appeals ("BVA") and the United States Court of Veterans Appeals ("COVA"). You indicated that the requested documents included, but were not limited to, all briefs, Statements of the Case, judgments, and opinions. You cited Supreme Court Rule 39 as the basis for your request. Your letter was referred to me because I was the assigned counsel in the COVA appeal.

Supreme Court Rule 39 does not relieve you of your responsibility to file all required documents with the Court. As a practical matter, you should already have a copy of all pertinent documents relating to the COVA appeal, in that you either prepared and filed the document yourself or you received a copy of the document from the Court or the Office of General Counsel. The same is true for those documents prepared during the administrative adjudication of your claim before the Department of Veterans Affairs regional office ("RO") or the BVA. Furthermore, the record on appeal in the COVA proceeding included all pertinent documents relating to the administrative proceedings before the RO and BVA. Finally, you may have previously requested that the RO provide you with a complete copy of your VA claims folder.

I am sorry we cannot assist you in this matter.

Respectfully,

Signed
PETER M. DONAWICK
Appellate Attorney
(202) 233-8556/8500
(202) 233-8566 (fax)

March/April 1999 DAV
Magazine Report

The DAV has urged the U.S. Department of Veterans Affairs to halt proposed rules that would change VA regulations to conform to court rulings that the DAV believes to be incorrect regarding the VA's duty to assist veterans in gathering evidence to support their claims.

In a letter opposing the proposed regulations, the DAV expressed the view that the Court of Veterans' Appeals (CVA) has misconstrued the term "well grounded" to be an essential condition to the VA's duty to assist claimants. DAV National Service Director Kenneth D. Wolfe said the VA historically has had a duty to assist claimants in establishing a well-grounded claim and not require veterans to establish a well-grounded claim on their own before the VA complies with it's duty to assist a claimant.

Under long-standing VA rules and practice prior to the CVA's ruling, a veteran had to submit evidence sufficient to establish that his or her claim was well grounded to be found entitled to the benefit sought. Because veterans often lack the understanding, ability, and resources to obtain records from public and private sources, the VA had the duty to assist the veteran in obtaining evidence to meet that requirement. By ruling that the veteran must obtain and submit evidence without VA assistance, we believe the court has rendered the VA's duty to assist meaningless, Mr. Wolfe said.

The court's view of a connection between the well-grounded requirement and the VA's duty to assist is the reverse of what existed before and what we believe Congress intended to continue, said Mr. Wolfe. "Any rulemaking at this point would necessarily require VA to in corporate the court's misinterpretation as the major premise for its regulation. The DAV submits that VA should undertake no rulemaking for this purpose."

Mr. Wolfe said Congress should enact legislation to override what the DAV believes to be incorrect judicial interpretations and restore the original application of the well-grounded claims standard and the VA's corresponding duty to assist veterans in meeting it. "To proceed with rulemaking now would merely ingrain the error and complicate matters even more," he said.

The intent of legislation passed by Congress was to require the VA to assist veterans with their claims. It was, therefore, the VA's duty to assist the veteran in finding documentation to support the claim making it "well-grounded." The CVA has ruled, however, that the veteran must first submit documentation to support a well-grounded claim before the VA's duty to assist comes into play. In effect, it requires veterans to prove their cases on their own without VA assistance, essentially relieving the VA from any obligation to help veterans and defeating the very purpose of the duty to assist.

"This creates an unnecessary burden for the disabled veteran," said DAV Washington Headquarters Executive Director David W. Gorman. "We believe Congress should promptly act to restore this fundamental principle to the VA's nonadversarial claims process."

Mr. Gorman said that legislation to restore the beneficial provisions that Congress intended should be a top priority for the 106th Congress. "Congress must shield veterans from this unnecessary requirement," he said.

Currently, the rulings have meant, "many claimants learn for the first time that their claims are not well grounded in a Board of Veterans' Appeals (BVA) decision," Mr. Wolfe told the VA. "Their efforts and time accomplished nothing. BVA or CVA affirmed the denial on a technicality that the claimant had never heard of until then. This clearly counters well-expressed congressional intent."

In his letter to the VA, Mr. Wolfe explained that Congress has acted repeatedly to preserve the informality and helpful nature of the administrative claims process. "The veteran's ability to submit a well-grounded claim may be dependent upon VA's faithfully discharging its duty to assist the veteran in gathering the evidence," he said.

"The finding that a claim is not well-grounded could provide a convenient basis to summarily deny an unknowing veteran's claim," Mr. Wolfe said. "Congress, in our view, never intended that veterans' claims be denied on such sheer technicalities."

"The DAV has urged the VA to take no further action toward making rules governing its duty to assist veterans," said Mr. Gorman. "We will work with the Congress to assure that these adverse court judgments are nullified and the VA returned to its intended role of assisting veterans seeking claims for disabilities."

APPENDIX E

UNITED STATES CODE ANNOTATED

TITLE 18

§1503. Influencing or injuring officer or juror generally whoever corruptly, or by threats or force, or by any threatening letter or communication, endeavors to influence, intimidate, or impede any grand or petit juror, or officer in or of any court of the United States, or officer who may be serving at any examination or other proceeding before any United States commissioner [United States magistrate judge] or other committing magistrate, in the discharge of his duty, or injures any such grand or petit juror in his person or property on account of any verdict or indictment assented to by him, or on account of his being or having been such juror, or injures any such officer, commissioner [United States magistrate judge], or other committing magistrate in his person or property on account of the performance of his official duties, or corruptly or by threats or force, or by any threatening letter or communication, influences, obstructs, or impedes, or endeavors to influence, obstruct, or impede, the due administration of justice, shall be fined not more than $5,000 or imprisoned not more than five years, or both.

(June 25, 1948, ch 645, § 1, 62 Stat. 769; Oct. 12, 1982, P. L. 97-291, § 4(c), 96 Stat. 1253.)

HISTORY; ANCILLARY LAWS AND DIRECTIVES

Prior law and revision:

This section is based on Act March 4, 1909, ch 32 1, § 135, 35 Stat. II 13; June 8, 1945, ch 178, § 1, 59 Stat. 234 (former IS U.S.C. § 241).

The phrase "other committing magistrate" was substituted for "officer acting as such commissioner" in order to clarify meaning.

Minor changes in phraseology were made.

UNITED STATES CODE ANNOTATED

TITLE 18

§ 1505. Obstruction of proceedings before departments, agencies, and committees

Whoever, with intent to avoid, evade, prevent, or obstruct compliance, in whole or in part, with any civil investigative demand duly and properly made under the Antitrust Civil Process Act [15 USCS §§ 1311 et seq.], willfully withholds, misrepresents, removes from any place, conceals, covers up, destroys, mutilates, alters, or by other means falsifies any documentary material, answers to written interrogatories, or oral testimony, which is the subject of such demand; or attempts to do so or solicits another to do so; or

Whoever corruptly, or by threats or force, or by any threatening letter or communication influences, obstructs, or impedes or endeavors to influence, obstruct, or impede the due and proper administration of the law under which any pending proceeding is being had before any department or agency of the United States, or the due and proper exercise of the power of inquiry under which any inquiry or investigation is being had by either House, or any committee of either House or any joint committee of the Congress-

Shall be fined not more than $5,000 or imprisoned not more than five years, or both.
(June 25, 1948, ch 645, § 1, 62 Stat. 770; Sept. 19, 1962, P. L. 87-664, § 6(a), 76 Stat. 551; Oct. 15, 1970, P. L. 91-452, Title IX, § 903, 84 Stat. 947; Sept. 30, 1976, P. L. 94-435, Title 1, § 105, 90 Stat. 1389; Oct. 12, 1982, P. L. 97- 291, § 4(d), 96 Stat. 1253.)

UNITED STATES CODE ANNOTATED

TITLE 18

§ 2071. Concealment, removal, or mutilation generally

(a) Whoever willfully and unlawfully conceals, removes, mutilates, obliterates, or destroys, or attempts to do so, or, with intent to do so takes and carries away any record, proceeding, map, book, paper, document, or other thing, filed or deposited with any clerk or officer of any court of the United States, or in any public office, or with any judicial or public officer of the United States, shall be fined not more than $2,000 or imprisoned not more than three years, or both.

(b) Whoever, having the custody of any such record, proceeding, map, book, document, paper, or other thing, willfully and unlawfully conceals, removes, mutilates, obliterates, falsifies, or destroys the same, shall be fined not more than $2,000 or imprisoned not more than three years, or both; and shall forfeit his office and be disqualified from holding any office under the United States.

(June 25, 1948, ch 645, § 1, 62 Stat. 795.)

HISTORY; ANCILLARY LAWS AND DIRECTIVES

Prior law and revision:

This section is based on Act Mar. 4,1909, ch 321, §§ 128,129, 35 Stat.

1111, 1112 (former I$ U.S.C. §§ 234 and 235).

Reference in subsec. (a) to intent to steal was omitted and incorporated in 18 USCS § 641.

Minor changes in phraseology were made.